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NECROBACILLOSIS OF THE SKIN.

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Clinical.

CHAS. M. STEMEN, M. D.

On October 3rd, 1910, James Flood, age twenty-eight, a government meat inspector, called at the office with a bad hand and arm. Having been surgeon for the Fowler Packing Company for over twenty years and having seen some four years ago a case similar to this one, and knowing that this man's position was that of an inspector, I recognized the trouble from which he was suffering, but was not conversant with the scientific names and terms. I told him that he was suffering from the same condition that they

Necrobacillosis of the Skin.—Left Hand.

find on the lip and legs of the sheep. He explained that about five days before while dissecting out an ulceration on the lip of a sheep he had accidentally scraped his hand on a tooth. I called in consultation twenty of the physicians and a number of the

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veterinary surgeons. Dr. J. N. Eagle, veterinary surgeon for the Health Department of Kansas City, Kansas, was the only one to recognize and name the condition from which Mr. Flood was suffering. The pain in this case was very excruciating. In fact so much so that for three or four days Mr. Flood had not slept excepting by the use of morphine. At the time his temperature was

Gas Bubbles Developing in a 12 Hour Culture.

one hundred and three (103F). His hand and arm was badly swollen. The ulceration was on the back of the hand and was about two and one-half inches broad by two inches in length, and raised at its highest about three-fourths of an inch. The sore consisted of cysts or blebs, each one, seemingly having its own peculiar

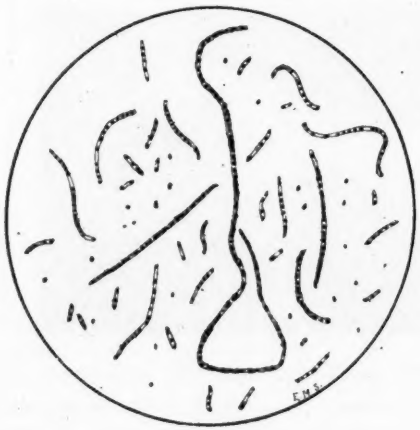

Fig. 3.

Bacillus Necrophorus x 950. Methylene Blue. Pure Culture.

Fig. 4.

Bacillus Necrophorus x 950. Aniline-Gentian Violet. Pure Culture.

appearance, some gray and some a bluish red. He had been using a bichloride pack. The blebs or cysts were all punctured and specimens taken by Dr. Shaw for pathological and bacteriological examination. I saw this young man twice daily. In the morning his temperature was one hundred and one (101F.) and in the afternoon one hundred and three (103F). He ran the same constitutional symptoms for about one week. The inflammation extended to the shoulder. His entire arm was rubbed thoroughly twice daily with unguentum Crede. The ulceration proper was treated with the bichloride pack and a twenty per cent (20%) solution of ichthyol applied to the parts adjacent to the ulceration. The constitutional treatment consisted of twenty grains of the iodide of potash three times daily with one teaspoonful of salts morning and night.

He made an uninterrrupted recovery and in three weeks the wound had entirely healed. This case was very interesting having never seen but one case before and not knowing what that was.

I am greatly indebted to Dr. J. N. Eagle, Dr. F. W. Shaw, Dr. J. L. B. Eager, and A. D. Melvin, D. V. S., for their timely assistance and co-operation in this case. I am only sorry that more of the physicians could not have seen this peculiar sore and ulceration.

I have looked up a great deal of literature and the best that I can find is a pamphlet published by the Bureau of Animal In-

dustry and written by A. D. Melvin and John R. Mohler, entitled "Lip and Leg Ulceration of Sheep." Necro Bacillosis.

All credit must be given Dr. Shaw for the pictures and the slides. I trust this little paper will bring out some new thoughts, and only hope that it may assist some in the alleviation of this terrible form of ulceration.

Bacteriology.

FREDERICK W. SHAW, M. D.

The B. necrophorus in this case was obtained from the seropurulent fluid of the vesicles and from the necrotic area near the border of the healthy tissue. If the vesicles have not been ruptured it may, as in this case, be obtained in pure culture.

Morphology.—B. necrophorus, from the vesicles on cover glass preparations, appears as coccoid forms, rods and thread-like filaments. The longer forms have a tendency to be slightly curved. The filamentous forms, then stained, have beaded appearance and I found a number of branching forms in a stained specimen of the seropurulent fluid which had stood in hermetically sealed tube in the incubator at 35. C. for three days. The bacillus stained with the ordinary aniline dyes. It does not stain with the Gram method.

The B. necrophorus varies in length from micrococci to filaments over 100 microms, and from .75 to 1.5 microms in width. Some of the filaments have one clubbed extremity, the other tapering and some show irregular thickening at the points where the filament takes the stain heavily. In general the filaments present the appearance of a chain of micrococci in a sheath, but when irregular staining takes place the round bodies take on a club shape. Again, the coccus-like bodies may be alternately arranged along the sides of the tube. This type was seen in large numbers in cover glass preparations from the sero-purulent material which stood in the incubator. Some of the rod shaped bacilli take the stain throughout, others at either or both ends, while some are beaded.

Cultural Characteristics.—As the B. necrophorus is a strict anaerobe its cultivation is very difficult. It only appears to develop between 30 c. and 40 c. with an optimum of 37 c.

In 2 per cent agar with peptone-salt bouillon media I obtained the best results. The media was placed in an anacrobeic culture tube and boiled. While the media was yet liquid it was inoculated. A partial vacuum was produced in the tube by a vacuum

pump and the tube closed. Other tubes were prepared in a similar manner but with out the vacuum and no growth resulted.

Shake Cultures.—In 12 hours, oval and round gas bubbles appeared in the lower part of the tube. Some of the bubbles which developed in the upper part of the tube made their way upward through the media and escaped. This happens when the media is not thick. Along the track of escape there develops a thin, white, feathery line. The bubbles, which are absorbed, show the same white, feathery growth on the lower aspect of the bubble as it contracts.

Stab Culture in agar-peptone buillon-salt.—In about 36 hours colonies make their appearance at the bottom of the needle track. They are few in number, grayish white with a slightly thickened centre surrounded by a thin grayish cloud. The cloud is composed of wavy threads. Gas bubbles develop along the track of the stab.

B. necrophorus does not develop in an atmosphere of CO2. Gelatine, in an agar-gelatine mixture, is not liquified.

Motion.—I failed to observe motion in this organism.

Odor.—Cultures give off a very disagreeable odor ably described by Ernst as between the odor of cheese and that of glue.

General Consideration of the Bacillus Necrophorus.

The bacillus necrophorus was probably first noticed by Dammann who published the results of his investigations of diphtheritic infections in calves, in November, 1876.

In 1878, Feldmann reported similar cases.

The organism was first investigated by Loffler in 1884. He obtained it from a rabbit, into whose chamber of the eye he had placed a small piece of tissue from a comdylomata lata.

In 1887, Bang and Schultz investigated an epidemic of hog cholera in Denmark. Bang found that he could kill hogs by feeding them pure cultures of the short ovoid and motile bacillus discovered by him in the tissues of the diseased hog. He, also, attributed the so called diphtheritic patches to this bacillus. Schultz found a long thread-like bacillus in the caseous patches which he named B. filiformis.

In 1888, Schultz refers to finding similar bacteria in abscesses in livers of cattle.

In 1889, Smith found a long bacillus in sections of ulcers of hog cholera.

In 1890, Bang established the identity of these organisms and to which he gave the name of nekrosebazillus.

In 1891, Schmorl reported a fatal enzootic occuring the previous year among his laboratory rabbits. From the caseonecrotic lesions he isolated a thread bacterium which he named streptothrix cuniculi. It has been identified with B. necrephorus.

The B. necrophorus is believed to be a normal inhabitant of the intestine of the hog and possibly of the cow and horse. It is also found in horse manure and soil contaminated with it.

The B. necrophorus can only enter the tissues when a solution of continuity of skin or mucus membrane exists, therefore the infection follows scratches or other injuries following a break in the skin or mucus membrane of susceptible animals.

The list of animals susceptible to the morbid influence of the B. necrophorus includes aves as well as mammalia; domestic and wild animals, both free and in captivity.

In animals the following tissues have been attacked by this organism, viz., necroses of the skin, viscera, mucus membranes of the mouth and upper air passages, genital tract and digestive tract, muscle, bone, hoof, cartilage and navel.

Ellerman, in 1905, reports the case of a nine months old infant who died with symptoms of larygnitis and pneumonia. A pseudo-diphtheria was found at necropsy. Sections of the uvula showed a deeply penetrating necrosis with long thread-like bacteria on the border of the living tissue. The study of the bacillus, the character of the necrosis and the fact that pneumonia developed secondarily, led him to assume a primary infection with B. necrophorus.

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APPENDICITIS.

C. R. LYTLE, M. D., Durham, Kansas.

Read before the Marion County Medical Society, April 6, 1910.

My efforts to present the subject of "Appendicitis" may be devoid of features that are regarded as salient, or features that are regarded as of primary importance to the surgeon, since it is a surgical disease; devoid, possibly, of features offering anything of of profit or novelty to this society. But my own views on the treatment of the disease have been so modified by experience and observation during the past year, that they are at least worthy of my consideration, and justify my departure in a measure from the usual orthodox treatment as taught by many leading men of today.

In meeting this disease in general practice, I am brought to the realization that there is a wide disparity between what one expects and ought to accomplish and what actually is accomplished, in convincing the laity of the best procedure in a given case. We cannot take away the patient's prerogative of refusing an operation, and we are therefore compelled to exercise the alternative of treating a surgical case from a medical standpoint. But the medical treatment is not limited to those cases only where the patient's prejudice against an operation cannot be overcome. We encounter many cases which come under our observation too late for a safe operation,—say within the first 24-36 hours. Hence, our best efforts are required to tide them over to a safe period when radical measures can be used with safety.

The first 80 or 85 cases which came under my observation, having been already diagnosed, were admitted to the hospital for operation, either for early immediate operation, or during the safe interval of attacks. These will scarcely enter into any prominence in this presentation, except as they bear directly on the palliative or medical measures to be outlined, as the rational treatment when operation is denied or contra-indicated.

That the disease is eminently a surgical one I think no one will deny, but in cases that we are forced or are pleased to treat medically, I am convinced that there is a right way that seemeth wrong, and a wrong way that seemeth right, in contra-distinction to many opinions regarded as authority. One of the salient points in the palliative treatment of appendicitis cases which is advanced by many, some of them men of note and authority, is the early locking up of the bowels; their argument

being that, by thus lessening the peristaltic wave, a favorable influence is brought to bear upon the spreading infective process. As Ochner would put it, "To permit peristalsis favors diffusion of the infection. To prevent peristalsis is to favor the formation of encompassing and defensive adhesions." It seems presumptous to take issue with the opinion of such eminent authority, but I I am convinced that this is correct theoretically rather than practically. To my mind, the locking of up the bowels is conducive to a greater infraction of those laws of nature which are in operation striving to bring about a localization of the inflammatory process. A static condition of the intestinal contents impregnated with myriads of coli communes which are being added to the already thronged area of inflammation, is certainly increasing the efforts of nature against the ravages of the arch enemy of the appendix.

Against this argument might be cited the definition of Dieulafoy, a Frenchman, of appendicitis—"that it is the conversion of an open to a closed appendix." This, however, is not correct, and cannot be borne out by clinical experience, as a large per cent of the cases operated upon disclose the fact that the appendiceal orifice remains open. Neither have I seen, in any case operated upon, a well defined and functioning "Valve of Gerlock", closing the appendiceal orifice. So in the locking up method, we favor a barrier to the possible normal avenue of escape against the least resistance, for the causative factor, of appendicitis.

If the attack is preceded by constipation, which is usual in my experience, and which has no doubt been an important etiological factor, why not roll away the stone from the door, and relieve a great embarrassment to a smothered appendix? The only obvious danger to the procedure of keeping the bowels open is the liability of breaking up the limiting walls of adhesions that nature is struggling to use to protect the surrounding parts against the infective process. The rythmical alternate contraction and relaxation of the muscular coat of the intestinal canal is mostly manifested in the muscular, mucous, and sub-mucous coats, though of course in a degree in the peritoneal coat. I fail to see how this slight motion can bring as much grief, to an inflammatory process relatively exterior to the movement, as an impacted bowel, with its pathogenic organisms which are in no way content with their normal habitat, but are ever improving benign conditions to migrate to where they can do the most damage. Furthermore, by the locking up process, we undoubtedly favor a vitiated blood supply and drainage to the diseased organ, as it receives its blood

supply from the same source as does the caecum, viz., the ileo-colic branch of the superior mesentery.

In my first cases in general practice, I followed the usual instruction, that of locking up the bowels as soon as diagnosis was made—some authorities permitting an initial purge, and many none whatever. Despite my instructions prohibiting any purge, in my absence, in one or two cases, one was given, with results satisfactory to the patient—immediate amelioration of the symptoms, diminution of pain, drop in temperature, less restlessness, and general sense of comfort. Not that all alarming symptoms suddenly disappeared, however, as the case, though relieved, went on to termination, but whether ending in abscess or general recovery, the symptoms were less aggravated and alarming than in cases where the fecal stream was brought to a standstill. I believe the majority of physicians use an initial purge, but even though we do this, and then permit a limited diet, every man's experience teaches him that a simple purge does not by any means empty the bowel, nor keep it comparatively empty, especially in the caecal area.

Again, any interference with the blood supply which may be encouraged by a distended bowel, predisposes to gangrene formation. But whatever the etiological factor, admitting that it is a bacterial disease, whether aided by trauma, uric acid irritation, congestion due to chilling, distended by ingress of colon contents, or foreign body, or whether the disease be of catarrhal, obliterative, recurrent, suppurative or gangrenous type, I am impressed from my observations that a comparatively empty cæcum is infinitely less menacing than a packed cæcum with its hordes of disease-producing germs perched on the threshold of a badly embarrassed and crippled organ. And most particularly is this treatment eminently rational if the orifice remains relatively or normally open, which, as we have already stated, it does. I would not recommend this treatment, however, if symptoms and physical signs of abscess formation were in evidence.

Another most salient point, in the treatment of these cases, not universally agreed upon, is the use of heat and cold, rather, heat or cold. Many say the ice bag, others say either, but after hearing the views of Dr. J. Chalmers Da Costa as to the relative value of each, I am convinced that the ice bag has a very small part, if any, in appendicitis cases. Cold may be of value in the very brief stage of hyperemia. But cold adds to stasis, and does harm, and we seemingly have the evidence that the ice bag is responsible for some of the cases of gangrene. Again, cold actually

antagonizes the migration of leukocytes, and the formation of adhesions. Heat is a remedy which favors limitation of the process. It relieves stasis, stimulates the activity of the leukocytes, favors the formation of an encompassing barrier of phagocitic cells, and aids the cellular proliferation which leads to the formation of adhesions. The ice bag may also serve to mask the symptoms, as does opium given early, for when it is applied before the diagnosis is fully made, it allays the pain, and lessens rigidity in many cases.

Therefore, in the application of remedial measures in those cases which positively will not submit to an operation, and in the cases which are not seen early enough to admit of safe operation, and where we have, therefore, to choose between a dangerous delay, and a more dangerous operation, I would outline the following treatment, which appears to me most rational, and which I have adopted with some modifications, in many cases:

Patient at rest. Bed in the Fowler position after third day, not extreme Fowler, as it is unpleasant to the patient, but enough to get good benefit of the force of gravity as applies to spread of infection throughout abdominal cavity. (2) Keep patient on right side or nearly so, for same reason that you would the Fowler position. (3) Hot water bottle to appendiceal region, regardless of location of pain, as soon as the diagnosis is made. (4) Restricted diet. (5) Saline laxative daily. (6) Opium to control pain.

This constitutes a generalized treatment, other symptoms and complications to be met as the case demands.

Since it is not appendicitis but peritonitis that kills our patients, it is well to consider the treatment recently advanced by John B. Murphy. If the case is one in which all prejudices have been overcome, and we are allowed to employ our best knowledge and skill, the treatment by Murphy seems highly commendable, as his statistics, upheld seemingly by other surgeons of note, show but 3% of deaths. The treatment consists in dealing with the infective process by operative measures, and then making a supra-pubic incision, introducing a drainage, and carrying it well into the pelvis. Place the patient in the Fowler position, and introduce large quantities of warm saline solution just inside the sphincter muscle by the drop method, using a catheter with extra holes in the side, and allowing the fluid to enter continuously about as fast as it can be absorbed. Whether or not this treatment has the effect of producing a reverse action of the lymph channel, as Murphy claims, it has proved highly efficacious. In addition to the 33 cases with but one death, which have been reported by Murphy up to the present year, 9 other cases, with no deaths, were

similarly treated by Da Costa, Gibbons and others at Jefferson Hospital in 1908.

In dealing with cases of appendicitis with a limiting wall that encompasses the pus area, it is unneccessary, no doubt, to suggest the greatest caution in the rough handling of these cases. While assisting a surgeon of extensive surgical experience, before a class of students, in the presentation of the case a slight pressure was made over the quite well defined abscess. It resulted in the sudden rupture of the abscess wall, and consequent liberation and distribution of pus. A general peritonitis was seemingly inevitable, but by an unusual second attempt on the part of nature, a second limiting wall was thrown around the suppurating area, which this time involved two-thirds of the abdominal cavity, and it was only after a desperate struggle that the patient's life was saved.

Referring again to pus cases and abscess formation, I freely acknowledge an error which I recently made in diagnosing a condition, by coinciding with a fellow practictioner. The case was running a typical and well defined appendiceal career of severe form, and in a little less time than we would reasonably expect pus formation, a mass giving the dull percussion note was detected in the right iliac fossae. A seemingly septic temperature and history of chill was all that was necessary to confirm the diagnosis. Operation was advised, but the friends objected, and nothing was left but to follow the medical treatment already outlined. A slow recovery followed, the mass still remaining, and I am now convinced that the pathology diagnosed as abscess was a portion of agglutinated omentum around the inflamed area—a fairly rare condition. This does not carry with it the idea that an operation was contraindicated, but does recall the fact that a mass in the diseased area may be an impacted caecum, agglutinated omentum or a collection of inflammatory exudate.

Other cases may be cited which are most convincing to me that many cases run such a typical career that the diagnosis is not always the easy matter that some seem to think. The number of unusual cases which come under our observation in which subsequent operation has confirmed the diagnosis, is sufficient to convince us that the disease is common, very common, much more so than some of our too conservative fellow practitioners can be convinced.

Since writing the foregoing, I notice an article in the A. M. A. Journal, by Dr. LeGrand Gourney, of Columbia, South carolina, in defense of the Oschner method, in which his data is based on 545 cases in his own experience, and with a reasonably low mortality,

but in the list he records 240 pus cases following the locking up method, a remarkably high per cent. This I maintain was due to his locking up procedure, for the per cent is very unusual. If such a per cent of pus cases had occurred in the ordinary country practice, rather than under hospital facilities, the mortality would certainly have been much higher.

But in conclusion, I wish to say that after a patient has had two well defined attacks of appendicitis, all medical treatment and palliative measures that can be instituted, no more permanently cure the case than do remedies given to allay the symptoms of the passage of gall stones through the gall duct effect a cure in the case of Hepatic Calculi.

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ETIOLOGY AND TREATMENT OF ULCERATIONS OF THE CORNEA.

W. H. GRAVES, M. D., Pittsburg, Kas.

Read before the Crawford County Medical Society, Sept. 15, 1910.

Knowing the cornea to be perfectly transparent and after once becoming involved to any great extent by any inflammatory process with the usual resulting opacities of some nature, followed by a more or less decrease in vision, is it any wonder that there has been, and will be, a great deal written on this very important subject. Realizing, as I do, the serious nature of an ulceration of the cornea, especially regarding vision, the subject, to me, has been intensely interesting. Again realizing that this condition of ulceration of the cornea occurs among the laboring class of people and that these people must have vision or be dependent, the subject becomes still more interesting.

Another point which has been constantly brought to my attention, is the fact that the laborer, especially of the lower type, is the most careless regarding eye injuries, we knowing that trauna coupled with neglect, is responsible for the majority of ulcerations. It is also a fact that a great majority of the men working in machine shops, etc., when having a foreign body embedded in the cornea, will have any one pick it out, and the man performing the service uses anything from a toothpick to a knife blade.

It has also been the observation of every oculist located near any large machine shops, that, time after time, the foreign body has not been removed, but all that has been accomplished is that the corneal tissue has been lacerated. It may be impossible for the man to leave work, as he may not care to do so because of time

lost, and continues through the day with the cornea exposed to infection and unable to resist because the cells have been lacerated and destroyed.

This man who must absolutely have vision, is the most careless. This explains one reason why a great deal of the oculist's work is among the laboring class of people. As a rule, among the men doing skilled labor, as the engineer, you will find him very particular regarding any eye injury, and as a rule they do not have the different eye injuries. These people are among the better educated class of men and naturally their hygenic surroundings are better.

On the other hand, a class of people that we often have different forms of ulcerations to deal with, is the farmer. I cannot say regarding all sections of the country, but in this territory I do not believe, as a whole, they realize the serious nature of an eye injury. I have often observed it to be the case that a farmer receiving an injury to the eye scratched from cutting hedge, will continue with his work until infection has occurred. This may be accounted for because of the extra trouble in stopping work and coming to town.

At any rate, it only goes to show that in a great majority of cases, neglect is responsible for corneal ulcerations.

As long as injuries are responsible for so many ulcerations, I feel that if they could in all cases receive immediate attention, that is, thoroughly cleaning the wound, conjunctival sac and cillia, and a bandage applied, most corneal wounds will readily heal.

There are many other factors producing corneal ulcerations, and among these a great deal is being written on the subject of intra-nasal suppuration as being an etiological factor.

I have never seen a case of ulceration of the cornea in which I felt that intra-nasal suppuration was the direct cause, but I do believe that an individual who has received a corneal lesion may be more prone to having an ulceration follow if he has any suppurative process going on in the nasal cavaity. I feel that phyctenular keratitis is aggravated if the patient had adenoid vegetation, but do not believe this to be the direct cause. I have observed that children having phyctenular keratitis are below par, and removing adenoid vegetations improves the general health and also the keratitis.

There are a few general diseases which produce corneal ulcerations. The general disease producing this trouble and which I have come in contact more than any other is small-pox.

Ulcerations occurring as a sequella of small-pox are very difficult to control because of the lowered vitality of the patient.

This fact is true in any form of ulceration, for an infection of

the cornea occurring in any person with lowered vitality is much more difficult to treat.

There are a great many varieties of corneal ulcerations and it is impossible to enumerate all the causes, but I have given you the most common causes as observed by myself.

Anyone coming in daily contact with the eye soon learns never to take anything for granted when dealing wtih an ulceration of the cornea, because after a certain stage has been reached, where the cornea has taken on a whitish haze, pus has formed in the anterior chamber, a foul-spreading ulcer located usually near the corneal center, and a patient who has spent many sleepless nights, coupled with all this, constant pain, and you have a picture of a cornea ulcer which is going to result in deterioration of vision, usually and a few cases, complete loss of vision.

It is an accepted fact, that if we could see all cases occurring from an injury as soon as the injury is received, this condition would not always arise, but this is not possible. It is surprising how many ulcerations occur from foreign bodies embedded in the cornea. Usually if a foreign body becomes embedded in the cornea, and, as is often the case, is allowed to remain several days, the cornea will take on an ulcerated condition around the foreign body. I have had patients with corneal ulcers, come with the statement that a foreign body has been removed. This is usually all that is necessary but if the cornea has taken on a slightly ulcerated condition immediately around the foreign body the patient should not be dismissed as all right. But if there is any doubt in the physician's mind, instruct the patient to return the following day. In treating a corneal ulcer, if it be of the simple variety, atropine, an antiseptic wash, and dark glasses, are usually all that is necessary. That which concerns us most though, is the ulcer, which if not properly handled from the beginning, will destroy vision. This form of an ulcer, regardless of its size or location, should be cauterized immediately. An ulcer, where the floor is filled with a dirty, foul material, and the once clear cornea has taken on a slightly hazy appearance, especially around the ulcer, your patient has suffered the night previous, do not give your patient an antiseptic wash to use himself and have him return the next day to see if there is any improvement, for in one night's time, especially if the ulcer in the beginning, is located near the pupillary area of the cornea, may so encroach upon the pupillary area of the cornea as to materially interfere with vision; for remember, the resulting scar. A cauterization, if done immediately and if applied to the ulcer only, will result in no larger scar than the area of the ulcer and a great deal of vision may

be saved. It is wonderful, the resistance of the exposed cornea, and again, it is wonderful how quickly this resistance can be lowered by an ulcer that once after getting a foothold, sometimes nothing can check the progress. After the ulcer has been properly taken care of, frequent cleansing of the eye, together with atropine and a bandage, may, in a great many cases, check the progress.

There are many other methods of treatment and any of them are helpful; such as the use of subconjunctival injection of various solutions; but first, attack the ulcer itself, with your treatment, always remembering to look well to the physical condition of your patient.

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CLEFT PALATE.

DR. G. W. JONES, Lawrence, Kansas.

Read before the Kansas Medical Society, May 6, 1910.

As to the etiology of the deformity known as cleft palate, let me call your attention to the embryological centers of development—the fronto-nasal plate, from which are developed, among other parts, the septum nasi, the central part of the upper lip and that portion of the superior maxilla containing the four incisor teeth—the so-called premaxillary bone; on each side the embryological superior maxillary plate, which, gradually growing forward, coalesces with the lower margin of the vomer, with the premaxillary bone, and with other derivatives of the fronto-nasal plate to complete the upper lip; the alveolus, the roof of the mouth, the soft palate, and the uvula. These are the anatomical structures that are involved to a greater or less extent in the deformities known as harelip and cleft palate, to the latter of which, principally, I will invite your attention.

It is evident, therefore, that the failure of either superior maxillary plate to unite anteriorly with the derivatives of the fronto-nasal plate will leave a single harelip; the failure of both superior maxillary plates to unite leaving a double harelip; while any failure to unite further back leaves a cleft of the hard palate or of the soft palate, or a bifurcation of the uvula.

The early writers spoke of these deformities as arrested development, as, doubtless, it is, but possibly not in just the sense in which it was formerly used; the older surgeons used "arrested development in the sense that there was an insufficient amount of tissue formed to allow the opposing edges of the structures comprising the hard and the soft palates to approximate; but this, in the main, is a mistaken notion,

as in practically all cases of cleft palate there is enough tissue present, but, for some cause, the union has never taken place, or, having taken place, the outward wedging of the lower jaw, tending to separate the halves, was set up before the union was strong enough to withstand the force, and the result has been a fissure of more or less width, and in length extending, it may be, from the tip of the uvula anteriorly, through the soft palate, hard palate, and the alveolus, as well as involving the soft parts in front in single or double harelip. The fissure may stop at any point from the tip of the uvula to the lip, but it rarely involves the anterior structures alone.

Dr. H. E. Dennett, of Boston, makes the interesting observation that several years before, when the lions of the London Zoological Gardens were fed on meat containing bones too large for them to crush and swallow, all the lions born during the prevalence of that practice had cleft palates, and died young. Whether this was attributed to insufficient calcium salts is not stated; but it is a matter of record that the plan of feeding was soon changed, when they were fed on small animals whose bones were easily crushed and eaten, with the result that all the young born thereafter were normal as to palatal defects.

To Dr. Warner, of Boston, is due the credit of the first surgical closure of a cleft of the hard palate, early in the 19th century. The first distinct operation for cleft of the soft palate was that introduced by Dr. Roux, a French surgeon of the early part of the 19th century. While haphazard efforts, with indifferent results, had been made before his time, nevertheless the operation of Roux was the first established which had a definite routine. The technique of Dr. Roux was practiced, and modified in turn by Von Grafe, Warren, Diffenbach, Liston and others, in an effort to render it easier of execution and more certain in results; Langenbach and Sir William Fergusson doing much for the whole subject of cleft palate.

Prior to 1869, the operation for the correction of this deformity was deferred until the patient had reached an age of sufficient discretion to enable him to appreciate the necessity for the operation, control his movements, and keep his mouth open throughout a rather tedious and painful procedure. Anesthesia had never been administered, for the fear that the blood might strangle the sleeping patient. In this year, however, (1869,) Thomas Smith, of St. Bartholomew's Hospital, London, devised the first mouth-

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1Reference Handbook Medical Science. Volume 2, page 179.

gag for this purpose, and, using both it and chloroform, was enabled to operate on patients of any age.; yet it does not appear that he operated until the little patients were in their fourth year.

I shall not mention the individual operations that have been devised from that day to the present time, save to say that they were mostly of the Roux, Warren or Fergusson types. With a literature resplendent with the most famous names in surgery from the time of Warren, Dieffenbach and Liston down to the time of men still in the limelight of modern surgery, it is amazing how few have been the men who have made real progress in this line of surgery.

In the discussion of a paper by Dr. Peck before the New York Surgical Society only four years ago, such eminent men as Howard Lilienthal and George Woolsey were apparently undecided as to the relative merits of surgery or the obturator; nor has it been the writer's good fortune to run across anything in the transactions of this Society since then to show that they have come to any definite conclusions.

In looking up the operative technique for cleft palate during the past two years, and visiting the men who have been receiving a liberal amount of attention from the medical press, it has been my fortune to run across a variety of operations, extending all the way from the crushing operation, with its high infant mortality, at one extreme, to the simple caressing bi-manual pressure on the sides of the cheeks in the effort to slowly train the parts together, at the other extreme. Then there is the operation that apparently is a studied departure from some operation of established merit; but whether for the purpose of being original, I am unable to say. Men doing an operation that has been perfected by a colleague rarely mention his name in connection therewith, though exceedingly generous to the filmy claims of the man from afar.

In my search for the light, I have taken from the profession at large all the good points my technique could assimilate This has left me especially indebted to Dr. Brophy. I am indebted to Dr. Brown for mechanical devices for gradually bringing the fully ossified bones into apposition. An idea that for a while I fancied was original with the writer, was that of placing strips of Z. O. plaster across the cheeks and face of the infant, in an effort to bring the separated halves of the maxilla into apposition. This simple measure, which is only preparatory to later surgical correction, is best begun when the infant is not more

2Annals of surgery. January, 1906. Pages 136 to 139.

than two or three days old, and consists of placing strips of plaster from one cheek across under the nose and onto the opposite cheek, which should be brought well forward to receive it. That portion of the plaster that crosses the cleft in the lip should be protected by rubber tissue; otherwise, the muco-integumentary line may become irritated. The muscular action of crying only forces the separated halves closer together. These strips are to be renewed as they become too loose to serve the purpose, care being exercised at all times to prevent irritation. You who have not tried this will be amazed at the rapidity with which these little jaws can be molded into correct position.

Where the cleft extends through and involves the soft parts in double harelip, no matter if the unsightly premaxillary bone be attached to only the frenum of the nose, do not yeild to the temptation to remove it, but slowly and carefully mold it into shape. This is very easily accomplished before the child is a month old, after which it becomes progressively more difficult, until, in later childhood, it is necessary to use a mechanical device, such as a double-threaded screw, that being wired to the molars, is placed crosswise the alveolus to gradually draw the jaw together, before resorting to final measures of surgical closure.

All the measures advised herein have to do with the slow process of gradual closure, though no less an authority than Dr. Brophy brings the halves of the hard palate into immediate apposition when the child is three weeks of age. I have never done this, though Dr. Brophy gets excellent results by suturing through the hard palate from muco-periosteum to osteoperiosteo-mucosa, and through onto the opposite side. The lateral halves of the hard palate in patients as old as twenty-one have slowly yielded to mechanical devices for drawing them together, thus making the final surgical correction easy and effective.

The patient having received intelligent pre-operative treatment, we are now ready for the steps of the operation.

Whether the three-weeks-old infant or the thirty-yearold-adult, have your patient in excellent physicial condition. Have any nasal catarrh that may be present as much under control as possible. Freshly cleanse nose, mouth and face with any of the suitable mouth washes. Place patient on operating table and anesthetize, preferably with ether, using the drop method. Place a sand-bag under shoulders, so as to drop head back and elevate chin; adjust mouth-gag. I prefer the Brophy gag, because it enables me to work with less danger of infecting the wound than the use of the Hewett, Whitehead, or any other gag I know of.

With a suitable forcep or the suture, draw tongue out and to one side. Re-cleanse mouth; and from this point on, you will find of inestimable value to have the volatilized ether delivered to patient through a rubber-tipped metal tube connected with a series of bottles containing ether, and which are, in turn, connected with a foot-bellows. This will enable a good anesthetist to keep your patient in a proper state of anesthesia without in the least being in your way or embarassing the operation.

In the next step of the operation, I find the most useful little instrument to be the Brophy knife and elevator. Beginning at the point of the V in the hard palate, with cutting edge of knife cut through the edge of the cleft on one side, and separate the muco-periosteal structure all along that side out almost as far as the alveolar border. It is well to remember that just to the side of the cleft on either side, there is a small sulcus in the hard palate, into which the muco-periosteal structure is most intimately attached. A little care just here will avoid an embarassing button-holing of your flap. Having reached now the outer limit of the flap, and separating it from the hard palate a little in advance of the point in the "V" and back to the posterior margin ofthe hard palate, do not cut the levator palati muscle, as this interferes with proper phonation, as well as with the opening of the Eustachian tube, and often renders the patient a little deaf. Loosen the muco-peritiosteal flap where it attaches to the posterior border of the hard palate, and, crowding up these tissues somewhat, loosen the structures on the upper side of the hard palate for an eighth to a quarter of an inch back. This will enable you to slide the entire flap over without producing undue tension. Now pare the edges of the muco-periosteal flap from the point of the "V" back to the tip of the divided uvula, and, with a short curved needle with an eye in the point, introduce folded silk carrier sutures into the muco-periosteal flap, almost as far to the lateral sides as it is loosened. Four of these on each side are generally sufficient. These are not carried across to the opposite flap, but having passed through the flap on one side the needle is stripped back, while the ligature is held with a finger forcep. Having treated the too sides alike, in the next step, we take the loop of one suture and, introducing it into the loop of the suture opposite, the first suture is drawn through from the periosteal surface of one flap, across and up through the periosteal surface onto the mucous surface of the opposite flap. Having done this with all four sutures, we have now a folded silk suture running across from the mucous surface of one flap through to the periosteal sur-

face of the same flap across to the opposite flap, and out onto the mucous surface of that side.

We will now thread silver wire of about the size of a No. 1 or small No. 2 cat-gut into the loop ends of the folded silk sutures. Press the folded silver wire so as to do as little trauma as possible, and draw it through both flaps, Having treated the four sutures in like manner, we will now thread the loose ends of the silver wire sutures through a thin lead plate, a scant sixteenth of an inch in thickness, an inch and three-quarters long, three-eighths of an inch wide at one end, and two-eighths of an inch wide at the other end, having a row of four holes through its center. With the larger ends of both plates to the rear, we will pass the four sutures through the four holes in each plate on each side of the cleft, twisting numbers 1 and 2 and 3 and 4 together on each side. We will now cut off the long ends of the silver wire, and by gentle manipulation and adjustment, and gradually twisting down the silver wire sutures, we will bring just enough pressure on the lead plates to nicely adjust the muco-periosteal flap in the center without tension tension. We have made no side incision in the muco-periosteal flap, as this is needless.

Now, take Van Horn or any other good horse-hair, and close up the coaptated line, which should be free from tension. We will use for this purpose interrupted sutures through all the layers of the flap, and extending to the tip of the uvula. We will not tie any of these horse-hair sutures until they are all placed, when with a small straight angled tenaculum, we will separate from the bunch of horse-hair ligatures each one, beginning with the tip of the uvula, which we will tie and leave long, cutting the others short as they are tied. Before cutting the ligature through the tip of the uvula, we will use that for gentle traction in adjusting the line of union, after which it will be cut short like the rest.

Before leaving the patient, we will cut away all of the twisted wire suture that we can spare and turn sharply onto the lead plate the short twisted ends of the wire.

You can do both the cleft of the palate and the harelip at one sitting; but you will find it better, it is believed, to wait about two months before doing the latter operation. For an operation of the hard palate such as I have described, it will require between an hour and one-half and two hours. To many, this is a serious objection; but, with careful anesthesia, the end results are so out of proportion to those gained by any other method of which I am aware, that it is well worth the extra time; and too, it has been my observation that the average surgeon operate

in less time on the platform than it requires in the operating room; I have seen over two hours consumed by this operation in the hands of the very best men in the world. Therefore, I regard as of less consequence the two hours time—or say, under favorable conditions, an hour and twenty to thirty minutes—for a completed operation, than I do the failure to get perfect results.

Summary.

We can disabuse our minds of the notion that there is loss of tissue in cleft palate.

The proper time to begin the correction of the deformity is at the tender age of 24 hours when Z. O. plaster in the hands of the general practitioner can do wonders in the way of facial cosmetics by bringing the parts in nice apposition for later surgical closure.

Lateral incisions, so universally practiced are neither necessary nor wise, as the lead plates will take off the tension and prevent sloughing of the flaps better than the most liberal incisions.

Taken in time, the most unpromising cases can be trained into normal facial lines that can be made permanent by later operation.

When the patient is a year or more old, a well fitted double threaded screw wired to teeth across alveolus can be tightened just a little every day until the margins of the cleft are brought into perfect apposition. This does not narrow the face as it only restores the normal relations.

The crushing operation, still practiced by some good men, is not only unnecessary, but is attended by such high infant mortality that the measure has no legitimate place in modern surgery.

Severing the levator-palati not only is unnecessary, but it is fraught with grave defects of both hearing and phonation.

The ideal time for surgical closure is any where from three weeks to nearly as many years and should never be deferred un til the child has begun talking, as the defects of speech are not easily overcome.

After operating on the child of more mature years, it will be necessary to teach and actually to **show** him how to form certain words; especially those having the sounds of the dentals, and the sound of "s" or "l," this is best done by having the patient practice before a mirror.

Looking back over the past half dozen years, the progress is seen to have been most gratifying; not only is this true in the treatment of the adult cases, but it is equally true in the wise

measures that have been devised to relieve infants of the handicap of this bizarre deformity; and it is the writers hope and belief, that the time has now come when no general practitioner in the entire country will permit a child he has ushered into the world to grow up without the intelligent pre-operative care that will quickly and surely place the little patient in condition for early and effectual surgical relief.

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THE NEW PROFESSION.

HUGH B. CAFFEY, M. D., Councilor Second District, Pittsburg, Kansas.

Read before the Sixth Annual Meeting of the Bourbon County Medical Society, Fort Scott, Kansas, December 20, 1909.

I am very grateful for the opportunity of meeting with you on this occasion in many respects, for the annual meeting of our county societies is, or should be the most important one of the year.

I think perhaps that I am guilty of negligence for not having visited your society oftener, in my capacity as councilor, but I have felt that you were old enough to stand alone and young enough to be vigorous and enterprising, therefore you were not in need of such assistance as the councilor is supposed to render. It is evident to me that you do not need advice, nor to be told of the benefits to be derived from organization, so I have chosen to rather speak of its ultimate results, which I believe, accounts for our standing as a profession, and for the fact that the future will see in us a **new** profession.

Nothing seems to be able to exist in the moral, political, social or intellectual life of the modern world that does not find outward expression in the form of some association or society. It has been wisely said, that "verily, if organization be a means of grace, we are saved." The growth of the spirit of organization is but one of the symptoms of the modern feverishness with which the profession of medicine is clamoring for supremacy amongst the learned sciences.

The representation which we have on all scientific boards, in the army, the navy, legislative departments of our government, the various experimental laboratories and schools for research work, which, backed by noted financiers, are continuously startling the scientific world with new and valuable facts, are other evidences of our progress from obscurity, empiricism and the realm

of fantasy and irrational juggling with herbs, roots and potions. Our profession is leading the world today in new discoveries which are essentially humane and because of this fact are of the greatest service to mankind.

The training which a student receives in passing through the high school, academy, college and the university before he is admitted to the medical school; then the raising of the standard of medical education is such as to make the new profession, soon to come on the stage of life, a body of brighter, more critical and better versed men than we or our predecessors.

The tendency to specialism and individual research work is steadily on the increase and marks an epoch in our present day progress. The impetus given to thought by the introduction of keener and more critical methods of investigation, augmented by the ability of the general profession to comprehend laboratory findings and to intelligently put into practice modern methods of diagnosis and treatment is rapidly becoming universal in its scope and gradually, though surely, we are on the threshold of a new era in medicine.

Justice to the science, the profession and the public, calls for substantial reasons for any great or radical change in the healing art.

To those disposed to criticise such investigation, we must say that the true interests of medicine have never suffered by acknowledging errors and seeking to amend them, as by so doing we give assurance of an honest desire to find the truth There may be yet some in our ranks who are unwilling to admit that any material change has taken place and others who admit the change but cannot see the improvement and long for the return of the "lost art," to such or rather to their patients we may extend our sympathy.

The traditions of medicine are, and should be cherished by all. We are proud of the men who could wrestle the sound theories of today from mongolian superstition, from Hippocrates and Galen who were "mantled with mysteries of their own romance."

The profession of yesterday was slow to accept new theories because the opinions of a few impractical men of learning and renown were given undue weight and hence retarded progress. Had their labors not been governed so much by hypothesis, empiricism and disputation, their great ability would have led to the development of richer trophies in medicine, and we can but lament that often their memories furnish but little more than monuments of wasted talent.

The medical mood of today does not respect authority unless sustained by demonstrative proof. It rejects dogmas from within as well as heresies from without. We have arrived at that stage which forces its students to that most valuable position, a **knowledge** of when a thing is proved and when it is not proved—a condition of affairs which sustains **real** medicine, and is a deadly enemy to quackery. We may still wisely adhere to the golden rule of Chomel that "it is only the second law of therapeutics to do good, the first being, not to do harm."

The profession today is in a receptive mood. We are watching and waiting for new theories and methods and most of us have been inclined to try them out without sufficient proof of their efficiency, and often at the expense of the patient. We need not marvel at the expression of Mulier that "as his constitution was not strong enough to withstand both disease and doctors, he would dispense with the latter," or the saying of Themison that "the study of medicine is a meditation on death."

But thanks to the new profession, the thorough student of the research laboratory, the great clinics of the world, when a new thing comes out it is in tangible form, with convincing proof of its merits.

In the words of Voltaire"' Nothing is more estimable than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, exercises his art with caution and pays equal attention to the rich and poor."

"If thou could'st doctor, cast
The water of my land, find her disease
And purge it to a sound and pristine health,
I would applaude thee to the very echo,
That should applaud again."

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Ethyl Chloride for Removing Warts.—Dr. Budinger (La Clinique, quoted by L'Union Pharmaceutique) recommends ethyl chloride for the removal of warts. A jet of the liquid is directed upon the wart for one minute and the operation is repeated every two days as long as necessary. A part of wart thus treated falls off, while the remainder shrivels up and gradually disappears, leaving a red spot. Superficial warts disappear readily under this treatment; with deeper ones the outer portion must be excised before applying the ethyl chloride.—Medical Fortnightly.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS: J. E. SAWTELL, CHAS. S. HUFFMAN, O. P. DAVIS.

Subscription Rates: $2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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EDITORIAL

It requires many smiles to dissipate the effect of one frown.

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Worries only serve to enhance the value of contentment.

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If your annual dues are not paid up for 1910 you will hereafter fail to receive the Journal.

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Preparations are already under way for the entertainment of the next meeting of the Kansas Medical Society to be held at Kansas City, May 4-5-6, 1910. Announcement will be made next month of the guest of honor who wiill deliver an address on a surgical subject. This meeting of our society will probably be the largest in its history and ample provisions will be taken by the Wyandotte County Medical Society for its care. The meetings will be held in the Masonic Temple and our thanks are due the Scottish Rites bodies for their generosity in allowing us its use. Dr. Chas. S. Huffman, the Secretary, has charge of the program which will be published at an early date.

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Kansas and Missouri have resumed reciprocal relations and a license to practice medicine will now be issued on diploma from reputable colleges to those who are licensed in either state prior to 1901. Those who have graduated since 1901 must pass an examin-

ation. This is a step in the right direction and the time should come when every state in the Union has reciprocal relations with each other. If one has the knowledge to pass the required examination in one state he should be entitled to practice in any state having the same requirements. If there could be such a thing as a National Board of Examination and Registration whose duty it would be to prepare a set of questions for each state the examination to be conducted by a board in the separate states then there could certainly be no exception taken as to the individual's qualifications. Let us hope this condition will be brought about.

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"606."—Evidence continues to pour in mostly from Europe,, of the remarkable efficacy of the Ehrlich-Hata's specific for syphilis and it bids fair to become one of the most important discoveries in medicine during the past decade. Ehrlich has collected reports of over 10,000 cases treated with "606" with not over a dozen fatalities (Tex. Med. Jour.), and the curative results are said to be marvelous. The good results reported now seem to be so everwhelming that its use will soon be universally justified. The technic has been improved and it is claimed that is is hardly more than one-third as toxic as when it was first introduced. It requires an absolute knowledge of the patient in that either a positive Wasserman or a demonstration of the spirochaeta pallida must be obtained before its use. There are also contradictions such as disturbances of the optic nerve, and marked organic disease especially of the cardio-vascular system and the central nervous system. It also requires a thorough knowledge of the technic of its introduction. It is said to act with lightning like rapidity upon primary, secondary and tertiary lesions, often healing them within fourteen days. If this drug proves to be the panacea for syphilis which present evidence tends to prove, then an enormous amount of human illness will be prevented.

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NEWS NOTES

THE MEETING OF THE COUNCIL OF THE KANSAS MEDICAL SOCIETY, WILL BE HELD AT TOPEKA, ABOUT JAN. 15, 1911.

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Dr. W. F. Fairbanks, of Kansas City, Kansas, spent November visiting in the east.

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The annual meeting of the Northeast Kansas Medical Society will be held at Topeka, February 9th, 1910.

Kansas City, Mo., has just passed an ordinance prohibiting the sale of fireworks within its limits. Would that other cities pass a sane Fourth law.

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Dr. E. R. Tenney was recently elected Coroner of Wyandotte County to succeed Dr. J. A. Davis, who had served two terms and was not a candidate for re-election.

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The A. M. A. Journal has since its introduction given a resume of practically everything published on "606." It deserves commendation for the completeness of the review.

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A Two Million Dollar Endowment Fund for the American National Red Cross Society.—President Taft is appointing special committees in the principal cities of the United States to assist in raising an endowment fund of $2,000,000 for the American Red Cross Society. A general committee composed of these special committees will have Secretary of the Treasury Franklin McVeagh as chairman.

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The Alumni Association of the Medical School of the University of Kansas.—At a meeting of the executive committee of the association, held in Lawrence, Kansas, recently, the following officers were elected: President, Dr. George M. Gray, of Kansas City, Kans.; vice-president, Dr. Marian Truehart, of Sterling, Kans.; secretary, Dr. H. P. Kuhn, of Kansas City, Mo.; members of the executive committee, Dr. C. C. Nesselrode and Dr. Logan Clendening. It is said that forty-eight per cent of the alumni of the school are practicing physicians in Kansas, and a movement has been started to enlist their active assistance in working for a bigger and better medical school.

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Dr. Keen Operated on.—Dr. W. W. Keen has been operated on for abdominal complications and is making excellent progress towards recovery. Knowing the interest that his many friends and former pupils have in his health, the Journal secured from an authorative source the following statement: While abroad last summer, Dr. Keen experienced some symptoms of intestinal trouble. He was examined by Dr. George A. Gibson, in Edinburgh, by Dr. W. Hale White and Mr. Mummery in London, and later in Berlin by Prof. Eiselberg of Vienna. All of them discovered an obscure tumor in the left lower abdomen. On having these facts confirmed and after consultation with his advisers, Dr. Keen decided that an

abdominal section was the only positive way to determine whether the mass was carcinoma, as seemed most likely at his age, or was non-malignant in character, and whether or not it was operable. Accordingly, as soon as possible after his return he went to Rochester, Minn., and was operated on November 9. It was found that the tumor was due to a perforating diverticulitis of the sigmoid with dense adhesions and moderate obstruction. There were two fecal stones, one of which had perforated and lay in a pocket outside the intestinal wall. It was necessary to remove a portion of the sigmoid.—Journal A. M. A.

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Surgeons Organize Congress.—The Clinical Congress of the Surgeons of North America was organized at the Hotel La Salle, Chicago, November 17th, the initial membership being made up of the surgeons in attendance at the series of clinics. It is proposed to continue these clinical reunions year by year in one of the large cities of the country. Membership is made up of surgeons who register at the regular sessions of the congress. The following officers were elected: president, Dr. Albert J. Oschner, Chicago; vice-president, Dr. John G. Clark, Philadelphia; editor and general secretary, Dr. Franklin H. Martin, Chicago; treasurer, Dr. Allen B. Kanavel, Chicago, and general manager, Mr. A. D. Ballou, Chicago.

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A Swindler Abroad.

Hotels, druggists, physicians, livery men and others, are warned against a man traveling from place to place presenting a card with the name "R. F. Hall" printed in the center. In the lower left-hand corner are the words "Parke, Davis & Co." and in the lower right hand corner the words "Detroit, Mich." This man is described as follows:

"5 ft. 6 or 8 inches, 150 lbs., fiend for Turkish cigarettes, about 27 years , complexion medium, wears nose glasses and continually takes them off and on; he is a swell dresser, good talker, fine appearance, wears one of those light colored slip on or off rain coats."

This individual has no connection with Parke, Davis & Co., and so far as heard uses the card to facilitate the passing of bogus checks.

Because of incidents like these nearly all concerns employing "drummers" forbid them to borrow money or seek credit, except upon individual responsibility and acquaintanceship. Therefore, those seeking credit or loans, especially from comparative strangers,

on the strength of their alleged connection with some important concern, should be treated as imposters.

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SOCIETY NOTES.

For the Missouri Valley Meeting.—Dr. Chas. H. Mayo has accepted an invitation to deliver the oration in Surgery at the Spring meeting of the Medical Society of the Misssouri Valley. Dr. Henrich Stern, of New York City, will deliver the oration in Medicine The meeting will be held at St. Joseph, March 16 and 17, 1911.

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The Republic County Medical Society met at Dr. Wm. Kamp's office at Belleville, Kansas, Nov. 10th, 1910. Papers were read by Dr. C. V. Haggman, Dr. Jos. A. Kohout and Dr. Wm. Kamp. All were thoroughly discussed by members present. The following officers were elected for the coming year: President, Dr. Wm. Kamp; Vice-president, Dr. J. B. Henry; Secretary-Treasurer, Dr. Jay C. Decker.

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Sumner County Medical Meeting.—Was held at the Commercial Club rooms, Wellington, Kansas, Thursday, Dec. 1, 1910. The ollowing program was arranged by Dr. Arch Jones, Councillor.: 1—Dr. J. J. Sippy, Medical Department of Health; 2—Dr. O. B. Wyant, Needed Medical Legislation, discussion led by O. P. Davis and A. S. Cloud; 3—Dr. Fred B. Lyon, Individualizing Gonorrhea, discussion led by G. K. Purvis and R. C. Young; 4—Dr. H. W. Neel, Care of the Parturient Mother, discussion led by D. A. Kisecker and C. W. Renick; 5—D. I. Maggard, Importance of Early Attention to Obstructive Respiration in Children, discussion led by J. M. Latta and A. R. Hatcher; 6—Dr. J. L. Gsell, Care of the Baby's Eyes, discussion led by F. M. Wilmer and J. G. Dorsey; 7—Dr. K. E. Haskins, Acute and Sub-Acute Endocarditis, discussion led by L. S. Coplan and L. A. Jacobus; 8—Dr. J. E. Oldham, Surgical Treatment of Diseases of the Chest, discussion led by A. D. Updegraff and G. W. Emerson. Intermission and Supper was served. 9—Dr. Arch Jones, My Job Counsellor; 10—Dr. O. P. Davis, Our Kansas Medical Society; 11—Dr. W. L. Courtwright, Paper; 12—Dr. L. P. Warren, Constipation, discussion led by Clinton Beesley and S. W. Spitler; 13—Dr. H. G. Shelly, Serum Therapy, discussion led by J. F. Costello and G. R. Little; 14—Dr. G. D. Pendell, X-ray in

Diagnosis and Treatment; discussion led by M. Hogan and R. E. Walker; 15—Dr. J. D. Clark, Toxemias of Pregnancy, discussion led by C. E. Bowers and H. F. Hyndman. T. H. JAMIESON, Secy.

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Obituary.

Charles H. McMillan, M. D., Northwestern Medical College, St. Joseph, Mo., 1893; died at his home in Leon, Kan., October 30, from tuberculosis, aged 40.

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James Lemmon, M. D., Joplin (Mo.) College of Physicians and Surgeons, 1882; a veteran of the Civil War; died at his home in Erie, Kan., October 7, from chronic nervous disease, aged 69.

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Joseph Frank Geenan, M. D., Rush Medical College, 1893; formerly of Toluca, Ill.; for four years Coroner of Marshall County; died at his home in Beloit, Kansas, October 20, from disease of the kidney, aged 42.

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Dr. W. F. Waite, a graduate of The University Medical College, died at his home in Kansas City, Kansas, aged 62 years. He was a member of the Wyandotte County and the State Medical Societies and a veteran of the Civil War.

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Joseph Claybaugh Kalb, M. D., Starling Medical College, Columbus, Ohio, 1857; of McPherson, Kan.; assistant surgeon of the Forty-second Ohio Volunteer Infantry, surgeon of the Forty-fifth Ohio Volunteer Infantry, and division surgeon during the civil war; died in Fort Worth, Texas, October 23, from cerebral hemorrhage, aged 79.

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MISCELLANEOUS

Envy puts more dents in contentment than poverty.—Physiologic Therapeutics.

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"As to the humors of medicine," said Dr. Ben Trovato reminiscently, "there is an old story about a woman who had an abdominal tumor which was found to weigh over eighty pounds after its removal, while the patient herself scaled only some sixty-four pounds. When she was recovering from the anæsthetic she is said to have remarked faintly to the surgeon that she might die happy if she was sure that he would save the growth. This

is as remarkable an instance of wit and tumor in our professional archives as I can recall at the moment.—N. Y. Med. Journal.

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A Noise Like a Salad.—A distinguished society leader of New York, lately returned from a motor trip through France, said that her most delightful experience was the hearing the French peasants singing the mayonnaise.—Everybody's Magazine.

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I am going into specialty work and can offer to the right man an excellent opportunity in a county seat town in Southern Kansas, excellent school, four banks, a good town of about 2300 population, good churches, good business people, a nice climate, and an established business of sixteen years duration. If the party so desires I will stay with him and introduce him for about two weeks. I want to get away not later than the middle of January.

Come and see is the better plan, or write for particulars.

Address Box P., Eureka, Kansas.

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Dickens makes the good wife of a good doctor say: "We are not rich in the bank but we have always prospered, and we have quite enough. I never walk with my husband but I hear the people bless him. I never go into a house of any degree but I hear his praises, or see them in grateful eyes. I never lie down at nights but I know that in the course of that day he has alleviated pain, or soothed some fellow creature in time of need. I know that from many thanks have often gone up in the last hour for his patient ministration. Is not this to be rich?"—N. Y. Med. Journal.

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"Medicine, sometimes impertinently, often ignorantly, often carelessly, called 'allopathy,' appropriates everything from every source that can be of the slightest use to anybody who is ailing in any way, or like to be ailing from any cause. It learned from a monk how to use antimony, from a jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmaster how to sound the Eustachian tube, from a dairy maid how to prevent smallpox, and from an old market-woman how to catch the itch insect. It borrowed acu-puncture from the Japanese, and was taught the use of lobelia by the American savage. It stands ready to-day to accept anything from any theorist, from any empiric who can make out a good case for his discovery or his remedy."—Dr. Holmes.

W. B. Saunders Company now have going through their presses a three volume work on Practical Treatment, written by international authorities and edited by those able clinicians, Dr. John H. Musser and Dr. A. O. J. Kelly, both of the University of Pennsylvania.

In looking over the list of contributors we can come to but one conclusion; namely, that this work will undoubtedly take rank as the very best on Treatment extant. The names of the authors carry with them the positive assurance of thoroughness. Indeed, each chapter is a complete monograph, presenting the most recent therapeutic measures in a really practical way.

As a general practitioner is required to know certain therapeutic measures more or less of a surgical nature, leading surgeons have been selected to present such subjects, This is an important feature, and, to our knowledge, not included in any similar work.

In every case the men have been most aptly chosen for their respective tasks, and under the wise editorship of Drs. Musser and Kelly there has been produced a work on Treatment that will remain for many years the last word—a source of practical information, easily obtained and readily digested.

The work will sell for $6.00 per volume, in sets only.

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Enthusiasm is the motive-force of progress. No really great deed was ever done in arts or arms, in literature or science that was not the product of enthusiasm. It discovered the circulation; it invented the ligature; it introduced vaccination and anesthesia, and it laid the gentle hand of healing on the wounds of humanity through antiseptic surgery.

We note its presence in the aphorisms of Hippocrates; in the orations of Demosthenes; in the demonstrations of Newton, and in the discourses of Pasteur. It was with Alexander in the field, as he conquered the world; it was with Plato in the grove as he founded philosophy. It was by the lonely lamp of Celsus and behind the sightless eyes of Galileo. It was on the battlefield with Pare and with Larrey and in the laboratory with Welch and with Leidy. It was in the hospital with Sydenham and Boerhaave, with Agnew and Samuel David Gross. It filled the lion heart of Abernethy, and it stirred the lordly soul of Hunter. It stimulated the labors of Washington and Cromwell, of Shakespeare and of Franklin, and it lit the councils of Cæsar and of Lincoln, of the great Napoleon and of England's "Grand Old Man." May we feel it; may we realize it; may we be animated by this immortal principle; may we be driven by this divine fire!—Dr. J. C. Da Costa—From N. Y. Med. Journal.

The Musical Bath.—An Englishman visiting New York for the first time was attracted by an odd sign over a Sixth avenue tonsorial parlor, which read "Musical Baths, 50 cents." He entered and asked for an explanation. The proprietor said his new bath tubs were equipped with music boxes, which played the latest tunes while one was bathing. He explained that a half dollar inserted in the slot would fill the tub with hot water, release a bar of soap, and a couple of towels, and at the same time start the music. The Britain decided to try the novel proposition. In about an hour, he emerged from the bath room wearing a decidedly worried and dissatisfied expression. "Did you enjoy the bath?" the proprietor asked. "Enjoy it!" said the King's subject, "well, hardly; don't you know the deuced thing started to play 'God Save the King,' and I had to stand up nearly an hour, and by that time the blooming water was cold.!"—Medical Herald.

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CLINICAL NOTES

If a patient with acute gonorrhea is kept in bed on a restricted diet, the saving of time in the cure will amply repay him for the confinement.—American Journal Surgery.

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Leukemia Treated by the Roentgen Rays—Clarke (Bristol Medico-Chirurgical Journal, September), reports four cases which he believes confirm the experience of other observers, that although Roentgen-ray treatment does not result in cure in leukemia, it gives a greater measure of relief in most cases than is derived from any other form of treatment, and prolongs life. If ordinary precautions are taken, and a careful watch kept on the state of the blood as regards the red cells and hemoglobin, and on the condition of the urine throughout the period of treatment, it seems to be devoid of danger. The presence of a slight albuminuria in one case and of marked glycosuria in another seemed to form no contra-indication to Roentgen-ray treatment, as they gave no trouble. The Roentgen rays should be applied over the long bones and vertebrae as well as over the spleen.—Journal A. M. A.

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The Treatment of Prostatitis.—Schaffner (Merck's Archives, November, 1910) regards the treatment of the catarrhal form of prostatitis as really that of posterior urethritis and he prescribes daily intravesical irrigations of solution of potassium permanganate in the strength of 1 in 5,000 gradually increased in strength to 1 in 2,000. After four or five days he commences using solu_

tions of silver nitrate in the strength of 1 in 2,000, having his patients visit his office every third day, using potassium permanganate one day and the silver solution at the next visit, and so continue to alternate. Internally he prescribes oil of santal in capsules each containing ten minims, and directs them to be taken not oftener than one every two hours. A combination which has given good results in his hands is the following:

℞ Mass of copaiba, ...gr. ii;
Oil of santal,.....mii;
Potassium bicarbonate,.....gr. iv;
Extract of kava kava,.....gr. ii;
Atropine sulphate,.....gr. 1-250.
M. ft. Pil. No. 1. Sig: One pill every two hours.

After the urgency of urination has subsided, the internal treatment may be discontinued and dependence placed on the local treatment.—N. Y. Medical Journal.

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One should always remember that the eye is just as much a part of the system as the leg or arm, and that many, many times it is only a symptom of a general ailment. While this point is known by all, its significance is oft times forgotten.

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Poliomyelitis.—A. L. Skoog, Kansas City, Mo. (Journal A. M. A. Nov. 19), says that there is as yet no specific treatment for acute poliomyelitis and that in many cases in his experience drugs have been used to excess. An early diagnosis is particularly to be desired, and two laboratory methods are mentioned: (1) the blood count, showing a mild leukocytosis with decided increase of lymphocytes and decrease of polymorphonuclears: (2) lumbar puncture. When the diagnosis is made and prodromal symptoms can be treated there is no objection to the moderate use of laxatives, and one of the most important therapeutic means is rest. Lumbar puncture may be of value therapeutically as well as for diagnosis. Hexamethylenamin may be used in the treatment of these cases. It is probably best to give the drug in as large doses as is safe for a period of a few hours and then to discontinue it for twenty-four hours. His practice is to give from 0.12 to 0.24 gm. to a child from 2 to 4 years of age, giving a dose every hour until three doses have been given, then giving no more until the following day at the same hour, when the course is repeated. This repetition may be employed as long as the acute symptoms persist. Thus we suddenly load the body with the chemical and then allow a short period of rest. We might give

from 3 to 8 gm. of the drug to the adult during a daily three or four hour period of its administration. During the past months he has used this method in five cases in the prodromal stage. Three patients recovered without any paralysis, one died, and another, whose case was of the foudroyant type, developed paralysis. Hexamethylenamin has also been given to a few children in families in which there was a fear of others acquiring the disease. In patients suffering from much pain and hypersensitiveness he has used the salicylates, of which aspirin was found most agreeable to children, and he has also obtained relief by applying heavy cotton dressing to the involved extremities. Partial immobilization may have been a factor in producing the results obtained. In his practice he employs isolation of patient and sterilization and disinfection of articles and excretions.

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Practical Points in the Management of Poliomyelitis and its Sequelae.—Taylor emphasizes the following points in the management of poliomyelitis:

1. The not infrequent occurrence of poliomyelitis in adolescents and adults.
2. The fairly frequent occurrence of abdominal palsy.
3. The uselessness of massage and electricity.
4. The value of rest in bed in the early stage, and of orthopedic and surgical treatment, both early and late.
5. The necessity for a systematic statistical investigation by State societies and boards of health.

Most of the references will be found in the "Report of the Collective Investigation Committee on the New York Epidemic of 1907," published in 1910 in the Monograph Series of the Journal of Nervous and Mental Diseases.—Medical Record.

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Nephritis following Tonsilitis.—H. W. Loeb, St. Louis (Journal A. M. A., November 12), says that recent experience has impressed two important facts on his mind; first, acute nephritis is a frequent sequel of tonsilitis; second, this is overlooked in practice by the majority of practitioners. He reports four cases, all physicians or occurring in the families of physicians and presumably therefore carefully observed. In each instance diphtheria and scarlet fever were positively excluded and the nephritis was of the hemorrhagic, non-scarlatina type without pyrexia or edema. In each instance also the tonsillar inflammation was mild in character and the course of the disease unusually slow, and in no

case was the nephritis discovered until the tonsillar affection had disappeared. From these cases and the literature, which is extensively quoted, he concludes as follows: 1. "Acute nephritis results from acute tonsillitis far more often than is generally believed. 2. The symptoms ordinarily are not manifested until some time after the inception of the disease. 3. The nephritis is of the hemorrhagic type and differs from that of scarlet fever in that pyrexia, edema, and oliguria are not marked symptoms of the disease. In addition, it follows the angina and is not concomitant as in scarlatina and diphtheria. 4. Judging from the course of the cases reported, there must be many in which a mild nephritis occurs incident to a tonsilitis, which goes on to resolution without patient or physician being conscious of its presence. 5. As each case of lacunar tonsilitis may be a potential source of acute nephritis, it is incumbent on practitioners to observe the urine, not only during the height of the disease, but for some time after as well. 6. Spontaneous or idiopathic nephritis is probably often due to a tonsilitis that has not been considered as an etiologic possibility. 7. Chronic affections of the kidney may well owe their origin to unrecognized acute attacks of nephritis of tonsillar origin. 8. Much light may be shed on this subject by a study of the urine in a large number of cases of acute tonsilitis."

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The pulse rate is a very important guide in determining the necessity for operation in acute appendicitis; but sometimes it should be altogether disregarded. If distinct pain and tenderness have not abated after twenty-four to thirty hours (especially if vomiting and more or less rectus rigidity coexist, but even without these) it is proper to operate without waiting further, no matter what the temperature and pulse rate; a gangrenous appendix may be found in a patient whose pulse is 70 and temperature 100 degrees. —American Journal of Surgery.

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Best Treatment for Chancroid.—Cleanse the chancroid with a bichloride solution (1 grain to the ounce); anesthetize with cocaine, eucaine or alypin; cauterize with a 10 per cent. solution of formaldehyde, i. e. 1 part of formalin or the official liquor formaldehydi to 3 parts of water. Then let the patient apply calomel, airol, aristol or europhen, 3 to 6 times a day. DO NOT use silver nitrate.—Therapeutic Medicine.

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